UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

PRADAXA (dabigatran)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED FORM TO 855-828-4992

CRITERIA:

- Documentation of one of the following diagnoses:
  - Atrial Fibrillation OR
  - Another condition requiring anticoagulation.
- Documented failure to maintain a therapeutic INR on warfarin or intolerance to warfarin.

AUTHORIZATION:

Authorization period is one year, or anticipated duration of treatment if shorter than one year

RE-AUTHORIZATION:

Updated letter of medical necessity

09/25/2013

http://health.utah.gov/medicaid/pharmacy